

CHAPTER 2

BECOMING A MEDICARE PROVIDER OR SUPPLIER



This chapter discusses how to become a Medicare provider or supplier.

Medicare Providers and Suppliers

The Medicare Program recognizes a broad range of providers and suppliers who furnish the necessary services and supplies to meet the health care needs of beneficiaries.

Part A

Medicare makes payment under Part A for certain services furnished by the following types of entities:

- Critical Access Hospitals;
- Federally Qualified Health Centers;
- Histocompatibility Laboratories;
- Home Health Agencies (including sub-unit);
- Hospice;
- Hospitals (acute care inpatient services);
- Indian Health Services Facilities;
- Inpatient Rehabilitation Facilities;
- Long Term Care Hospitals;
- Multiple hospital components in a medical complex;
- Organ Procurement Organizations;
- Psychiatric units (of hospital);
- Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatorium);
- Rural Health Clinics; and
- Skilled Nursing Facilities (SNF).

Part B

Medicare makes payment under Part B for certain services furnished by the following:

- Ambulance service suppliers;
- Ambulatory Surgical Centers (ASC);
- Clinical psychologists (CP);
- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers (including pharmacies);
- End-Stage Renal Disease Facilities;
- Home Health Agencies (outpatient Part B services);
- Hospitals (outpatient services);
- Independent diagnostic testing facilities;
- Nurse practitioners (NP);
- Occupational therapists in private practice
- Other nonphysician practitioners (NPP);
- Outpatient physical therapy (PT);
- Outpatient speech-language pathology suppliers;
- Physical therapists in private practice;
- Physicians; and
- SNFs (outpatient services).

Physicians

The Medicare Program defines physicians to include the following:

- Doctors of medicine and doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Chiropractors;
- Doctors of podiatry or surgical chiropody; or
- Doctors of optometry.

In addition, the Medicare physician must be legally authorized to practice by a state in which he or she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice. The issuance by a state for a license to practice medicine constitutes legal authorization. A temporary State license also constitutes legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards are used in determining whether the physician has legal authorization. If the State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Interns and residents include physicians who:

- Participate in approved postgraduate medical training programs; or
- Are not in approved programs, but are authorized to practice only in a hospital setting (e.g., have temporary or restricted licenses or are graduates of foreign medical schools).

The status of senior residents who have staff or faculty appointments or are designated as fellows does not change for the purpose of Medicare coverage and payment.

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. This includes services furnished in a setting that is not part of the provider where (among other things) the provider has agreed to incur all or substantially all the costs of training in the nonprovider facility. The Medicare Contractor must be notified when interns, residents, and providers enter into this type of agreement. When a licensed intern or resident physician performs the services but the provider incurs little or none of the training costs, the services are paid under the Medicare Physician Fee Schedule (MPFS). Medical and surgical services furnished by the intern or resident are considered to have been furnished in his or her capacity as a physician, not in his or her capacity as an intern or resident when:

- The services furnished are not related to the training program, the services are furnished outside the training program facility, and the following criteria are met:
 - The services are identifiable physician services that require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition and
 - The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed
- The services furnished are not related to the training program, the services are furnished in an outpatient department or emergency room of the training program hospital, and the following criteria are met:
 - The services are identifiable physician services that require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition
 - The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed and
 - The services can be separately identified from those services that are required as part of the training program

A teaching physician is a physician (other than an intern or resident) who involves residents in the care of his or her patients. Generally, the teaching physician must be present during all critical and key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the MPFS.

Practitioners

The Medicare Program defines a practitioner as any of the following to the extent that an individual is legally authorized to practice by the state and otherwise meets Medicare requirements:

- Physician assistant (PA);
- NP;
- Clinical nurse specialist (CNS);
- Certified registered nurse anesthetist (CRNA);
- Certified nurse midwife (CNM);
- CP;
- Clinical social worker (CSW); or
- Registered dietician or nutrition professional.

Enrolling in the Medicare Program

To obtain reimbursement from Medicare, providers and suppliers must first enroll in the program by completing the appropriate Provider/Supplier Enrollment Application. In the enrollment process, the Centers for Medicare & Medicaid Services (CMS) collects information about the applying provider or supplier and secures documentation to ensure that the he or she is qualified and eligible to enroll in the Medicare Program. Depending upon provider or supplier type, one of the following forms is completed to enroll in the Medicare Program:

- Form CMS-855A: Institutional providers (see the Institutional Providers and Suppliers Section below for additional information);
- Form CMS-855B: Organizational suppliers including group practices (see the Physician-Directed Group/Clinic Practice Section below for additional information);
- Form CMS-855I: Individual physicians/practitioners who bill Medicare directly (see the Individual Physicians and Nonphysician Practitioners Section below for additional information);
- Form CMS-855R: Individual physicians/practitioners; allows payment to a group practice or other eligible party (see the Reassignment of Benefits Section below for additional information); and
- Form CMS-855S: DMEPOS suppliers.

The following forms are often required in addition to the CMS-855 form:

- Form CMS-588: Medicare authorization agreement for electronic funds transfers (for providers who choose to have payments sent directly to their financial institution);
- Form CMS-460: Agreement to become a Part B participating provider or supplier who will accept assignment of Medicare benefits for all covered services for all patients (see the Participating and Nonparticipating Providers and Suppliers Section below for additional information); and
- Electronic Data Interchange Agreement: Agreement to follow provisions related to electronically submitting claims to Medicare Contractors.

The above forms are available at

www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website.

Additional forms, which may vary from state to state, may also be required in order to enroll in the Medicare Program. These forms include the following:

- State medical license;
- Occupational or business license; and
- Certificate of Use.

After all forms have been completed and signed, the packet is then mailed to the appropriate Medicare Contractor for processing. Information about where to send the packet can be found at

www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp#TopOfPage on the CMS website. For most applicants, the enrollment process takes 60 days. CMS requires its Contractors to process 90 percent of enrollment applications within 60 calendar days of receipt or earlier and 99 percent of applications within 120 calendar days of receipt.

When an enrollment change occurs, the change must be reported to the Medicare Contractor within 90 days by completing the same form that is used for initial enrollment in the Medicare Program.

Upon acceptance into the Medicare Program, providers and suppliers are assigned certain identification numbers:

- National Provider Identifier

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of the Department of Health and Human Services (HHS) adopt a standard unique identifier for health care providers, suppliers, health plans, and organizations called the National Provider Identifier (NPI). All HIPAA-covered entities (including Medicare, Medicaid, private health plans, and all health care clearinghouses) must use only an NPI to identify HIPAA-covered health providers in standard transactions by May 23, 2007. Small health plans (less than 5 million dollars in annual revenues) must use only an NPI by May 23, 2008. These transactions include claims, eligibility inquiries and responses, referrals, and Remittance Advices. The NPI will replace the health care provider identifiers now being used in standard transactions including Medicare legacy identifiers (PIN, UPIN, Online Survey Certification and Reporting [OSCAR] numbers, and National Security Clearinghouse numbers). Obtaining an NPI does not eliminate Medicare Program enrollment requirements for health care providers and suppliers who wish to serve beneficiaries. The advantages of using an NPI include the following:

- Simpler electronic transactions of HIPAA standard transactions;
- Standard unique health identifiers for health care providers, health plans, and employers; and
- More efficient coordination of benefits transactions.

Providers and suppliers can apply for an NPI using one of the following methods:

- Visit <https://nppes.cms.hhs.gov> on the CMS website and complete the web-based application;
- Call (800) 465-3203 to request a paper application; or
- Submit an application to the National Plan and Provider Enumeration System via Electronic File Interchange.

The NPI Web Page for all health care providers and suppliers is located at www.cms.hhs.gov/NationalProvIdentStand on the CMS website. This page also contains a section a section for Medicare fee-for-service providers.

- Provider Identification Number (PIN) or individual billing number, which
 - Identifies who furnished the service to the beneficiary on the Medicare claim form
 - Allows providers and beneficiaries to receive payment for claims filed to the Medicare Contractor
 - Is required on all claims submitted to the Contractor; an “unprocessable” claim denial will result if the PIN is not included in the appropriate claim block or claim field and
 - Is issued by the Contractor
- Unique Physician/Practitioner Identification Number (UPIN) or individual identification number, which is:
 - A national number used to identify physicians/practitioners who order or refer services
 - A permanent number that may be used in any state where physicians/practitioners practice
 - Received by all physicians/practitioners enrolled in the Medicare Program who order or refer beneficiary services even though they might never bill Medicare directly
 - Received by individual physicians/practitioners (one number is assigned regardless of the number of practice settings) and
 - Assigned by CMS

The following services require a UPIN on the claim form:

- Consultation services;
- Routine foot care;
- DME and other medical supplies;
- Orthotic/prosthetic devices, including optical supplies;
- Most diagnostic services, including laboratory and radiology services;
- Services by independently-practicing PTs or OTs; and
- Any other service that is ordered or referred.

Institutional providers are assigned the following identifying number by the Medicare Contractor:

- OSCAR, which is
 - A Medicare billing number and unique identifier and
 - Issued by the CMS Regional Office

Institutional Providers and Suppliers

Institutional providers and suppliers must simultaneously contact their local State Agency (SA), which determines whether Medicare participation requirements and State requirements are met and evaluates the provider or supplier's performance and effectiveness in furnishing a safe and acceptable quality of care. To find contact information for SAs, visit www.cms.hhs.gov/apps/contacts/ on the CMS website.

Individual Physicians and Nonphysician Practitioners

Individual physicians and NPPs bill the Medicare Contractor directly for their services and are issued an individual PIN. The address tied to the PIN is usually the physician or NPP's billing or mailing address, which may differ from the address where medical services are furnished.

Physician-Directed Group/Clinic Practice

A physician-directed group/clinic practice may be a partnership, association, or corporation composed of physicians or NPPs. Physicians and NPPs who wish to file claims as part of a group/clinic unit must request a group/clinic PIN number for billing purposes. The address tied to the PIN is usually the group/clinic's billing or mailing address, which may differ from the address where medical services are furnished.

Reassignment of Benefits

Ordinarily, Medicare pays the provider who furnishes the service. In limited situations, Medicare may allow physicians and practitioners who furnish services to reassign payment to another person or entity. This person or entity then bills Medicare on behalf of the physician or practitioner and receives payment for the services furnished. To reassign payment, each physician and practitioner within a group/clinic must complete Form CMS-855R, which states that he or she agrees to turn all monies over to the group/clinic. After the reassignment agreement has been signed, the Medicare Contractor will tie the individual provider's PIN to the group/clinic PIN. The group/clinic PIN is then used when claims are submitted for services performed as part of the group. Form CMS-855R must be completed and returned to the Medicare Contractor within 90 days of the effective date of the change in order to:

- Add a new reassignment;
- Terminate a current reassignment;
- Add a new practice location(s) for a current reassignment;
- Delete a practice location(s) from a current reassignment; or
- Change income reporting status.

Participating and Nonparticipating Providers and Suppliers

The chart below explains the two types of providers and suppliers in Part B of the Medicare Program.

Participating and Nonparticipating Medicare Part B Providers and Suppliers	
Part B Participating Providers and Suppliers	Part B Nonparticipating Providers and Suppliers
Accept assignment of Medicare benefits for all covered services for all patients	May accept assignment of Medicare claims on a claim-by-claim basis (see below for the provider specialties and services that must always accept assignment)
Receive higher Medicare Physician Fee Schedule allowances than nonparticipating providers and suppliers	Receive lower Medicare Physician Fee Schedule allowances than participating providers and suppliers for assigned or nonassigned claims
Limiting charge provisions are not applicable (Medicare payment is accepted in full)	Are held to a limiting charge when submitting nonassigned claims (with the exception of pharmaceuticals, equipment, and supplies); may collect up the limiting charge at the time services are furnished
Included in the Medicare Participating Physician and Supplier Directory	Not included in the Medicare Participating Physician and Supplier Directory

By completing and signing Form CMS-460, the provider or supplier has formally notified CMS that he or she wishes to participate in the Medicare Program and will accept assignment of benefits for all covered services for all Medicare patients. Assignment means that the provider or supplier will be paid the Medicare allowed amount as payment in full for his or her services. The following services are always subject to assignment:

- Clinical diagnostic laboratory services and physician laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of PAs, NPs, CNSs, CNMs, CRNAs, CPs, CSWs, and medical nutrition therapists;
- ASC services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; and
- Ambulance services.

Participation is valid for a yearlong period from January 1 through December 31. Active participants receive a participation package during the Medicare Contractor Open Enrollment Period, which is usually in November, when they can change their participation status for the following year. Providers and suppliers who wish to continue participating in the Medicare Program do not need to sign an agreement each year. The current agreement will remain in effect through December 31 of the calendar year in which the Medicare Contractor is notified about a change in status. Once Form CMS-460 is signed, CMS rarely honors a provider or supplier's decision to change participation status during the year.

Medicare allowed amounts can be found in the MPFS, which establishes payment policies and rates for over 10,000 procedures performed by providers, suppliers, and certain NPPs (e.g., NPs, PAs, and PTs). The MPFS is updated annually based on a formula defined by Medicare law and through a formal rulemaking proceeding.

The MPFS is based on the premise that if service "A" requires twice as many resources as service "B," service "A" should be paid twice as much as service "B." The payment amount for each service paid under the MPFS is the product of three factors:

- Relative Value Unit (RVU) for the service. From the simplest office visit to complex surgical procedures, the MPFS assigns RVUs that reflect the resources involved in completing the service and include:
 - Provider work component (the time, intensity, and technical skill required to furnish a service) which, in general, does not change from year to year except when CMS determines that the RVUs should be revised either on a case-by-case basis or as part of a statutorily required comprehensive five year review
 - Overhead component (all categories of practice expenses except for malpractice insurance costs) and
 - Malpractice expense component (the cost of obtaining malpractice insurance), which does not generally change from year to year except when CMS determines that the RVUs should be revised either on a case-by-case basis or as part of a statutorily required comprehensive five year review
- Geographic adjustment factor for each MPFS area, which recognizes that the costs incurred by providers vary depending on the location where they practice. The geographic adjustment factor is applied separately to each component (work, practice, and malpractice expense) of each service.
- Nationally uniform conversion factor for the service, which converts RVUs into payment amounts. Congress requires CMS to update the conversion factor annually according to a formula set by law.

The nonparticipating provider or supplier may choose to accept assignment of Medicare claims on a claim-by claim basis and may charge the beneficiary up to the limiting charge or the maximum amount that can be charged for the services furnished (unless prohibited by an applicable State law). The limiting charge is 115 percent of the MPFS amount.

The chart below depicts an example of a limiting charge.

Example of a Limiting Charge

Medicare Physician Fee Schedule Allowed Amount for Procedure "X"	\$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure "X"	\$190.00 (\$200.00 x .95 = 5 percent lower than Medicare Physician Fee Schedule allowed amount)
Limiting Charge for Procedure "X"	\$218.50 (\$190.00 x 1.15 = 115 percent of Medicare Physician Fee Schedule allowed amount)
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider or Supplier	\$66.50 (\$38.00 plus \$28.50) Coinsurance - 20 percent of Medicare Physician Fee Schedule allowed amount (\$190.00 x .20 = \$38.00) PLUS \$218.50 limiting charge - 190.00 nonparticipating provider/supplier allowed amount \$ 28.50 allowed amount

The limiting charge applies to the following regardless of who furnishes them or bills for them:

- Physicians' services;
- Services and supplies commonly furnished in physicians' offices that are incident to physicians' services;
- Outpatient PT and occupational therapy services furnished by an independently practicing therapist;
- Diagnostic tests; and
- Radiation therapy services including x-ray, radium, radioactive isotope therapy, materials, and technician services.

The chart below illustrates the payment amounts that participating and nonparticipating providers and suppliers receive.

Participating and Nonparticipating Provider/Supplier Payment Amounts

	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	\$125.00	\$125.00	\$109.25
Medicare Physician Fee Schedule Allowed Amount	\$100.00	\$ 95.00	\$ 95.00
80 Percent of Medicare Physician Fee Schedule Allowed Amount	\$ 80.00	\$ 76.00	\$ 76.00
Beneficiary Coinsurance Due to Provider/Supplier (after deductible has been met)	\$ 20.00	\$ 19.00	\$ 33.25
Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying the provider/supplier)	\$100.00	\$ 95.00	\$109.25 (\$95.00 x 1.15 – limiting charge)

Private Contracts with Medicare Beneficiaries

The following physicians who are legally authorized to practice medicine, surgery, dentistry, podiatry, or optometry by the state in which such function or action is performed may opt out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- Doctors of medicine;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Doctors of podiatric medicine; and
- Doctors of optometry.

The following practitioners who are legally authorized to practice by the state and otherwise meet Medicare requirements may opt out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- PA;
- NP;
- CNS;
- CRNA;
- CNM;
- CP; and
- CSW.

The opt out period is for two years unless it is terminated early or the physician or practitioner fails to maintain opt out. Opt outs may be renewed for subsequent two-year periods. The physician or practitioner must opt out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations. In emergency or urgent care situations, the physician or practitioner may treat a beneficiary with whom he or she does not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ ("OPT-OUT" physician or practitioner emergency or urgent service).

Medicare will make payment for covered medically necessary items or services that are ordered by a physician or practitioner who has opted out of Medicare if:

- He or she has acquired a UPIN; and
- The items or services are not furnished by a physician or practitioner who has also opted out of Medicare.

Protecting Your Practice

Engaging the Services of Billing Services or Consultants

Billing services or consultants may be engaged to submit claims to Medicare. Since providers and suppliers are responsible for any Medicare payments generated from claims submitted by billing services or consultants, they should complete the following activities:

- Review reports regarding claims billed to ensure consistency with their records; and
- Keep complete administrative records for seven years.

Providers and suppliers should ensure that billing services or consultants:

- Provide periodic reports regarding claims billed on their behalf, including how much Medicare paid if the billing service or consultant receives payments;
- Protect your identification numbers and any other information used to act on your behalf;
- Protect the confidentiality of patient data used in the submission of claims;
- Do not change procedure codes, diagnostic codes, or other information furnished by you or your organization without your knowledge and consent; and
- Provide all correspondence received from Medicare.

Hiring New Employees

When hiring new employees, providers and suppliers should:

- Select competent and ethical employees;
- Develop internal controls within the organization in order to minimize risk;
- Implement procedural checks and balances to ensure appropriate interactions with Medicare; and
- Conduct periodic quality checks of sensitive processes (e.g., the posting of account receivables).

Free or Discounted Services

If a provider or supplier furnishes free or discounted services (or a portion of free or discounted services), the services cannot be billed to Medicare or any secondary policy. It is unlawful to routinely waive the collection of deductibles, coinsurance, and copayments. If the patient is legitimately unable to pay for the services and this information is documented in the patient's records, the waiver of deductibles, coinsurance, and copayments is not considered unlawful.

Referrals

When a beneficiary requires a referral for specialized medical care or certain diagnostic tests or supplies, providers and suppliers should:

- Implement a process to ensure that only the services or tests ordered were furnished. For example, when reviewing the results of diagnostic tests, note whether additional or more complex tests were performed.
- Whenever possible, specify the reason the services are being ordered. For example, if diagnostic tests are ordered as part of a routine physical examination, the referral should include this information.
- Personally complete all medical information on referrals. Ensure that the patient's name and address is included on the referral before signing it. Never sign blank certification forms that justify Medicare payment for items such as home oxygen, wheelchairs, hospital beds, and prosthetic devices.
- Where applicable, specify the quantity of medical supplies that are needed.
- Be suspicious of entities that offer discounts, free services, or cash when ordering services.
- Never certify the need for medical supplies for patients who have not been seen and examined.

Contractual Arrangements

Providers and suppliers must consider numerous legal and compliance factors when they contract with individuals and other entities such as:

- The types of agreements and paperwork that must be executed;
- Ethical standards of conduct;
- State and Federal regulations; and
- Confidentiality obligations.

Compliance Programs

Implementing a compliance program can assist in establishing an environment that promotes prevention, detection, and resolution of conduct that does not conform to legal, ethical, or program requirements. Although compliance programs are strictly voluntary, adopting one may be beneficial to providers, suppliers, and other health care entities. The Office of Inspector General (OIG) has identified seven fundamental elements of an effective compliance program:

- Implementing written policies, procedures, and standards of conduct;
- Designating a compliance officer and compliance committee;
- Conducting effective training and education;
- Developing effective lines of communication;
- Enforcing standards through well-publicized disciplinary guidelines;
- Conducting internal monitoring and auditing;
- Responding promptly to detected offenses; and
- Developing a corrective action plan.

To find OIG compliance program guidance, visit www.oig.hhs.gov/fraud/complianceguidance.html and www.gpoaccess.gov/fr on the Web.

Promoting Cultural Competency and Enhancing Quality in Your Practice

The 2000 U.S. Census confirmed that our country is becoming increasingly diverse. Racial and ethnic minorities make up 30 percent of the American population and are expected to increase to 40 percent by 2030. Some 47 million U.S. residents speak a language other than English. With the increasing diversity of the U.S. population, providers and suppliers are more and more likely to encounter situations that require the delivery of culturally competent care, access to a vast array of language services, and supportive health care organizations. Addressing a patient's social and cultural background will assist providers and suppliers in delivering high quality, effective health care and increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

The HHS Office of Minority Health and Science Applications International Corporation have developed a free interactive web-based training cultural competency course titled *A Family Physician's Practical Guide to Culturally Competent Care*. The course assists physicians in preparing for the increasingly diverse patient population and furnishing the highest quality of care to every patient regardless of race, ethnicity, cultural background, or ability to speak English as their primary language. The course focuses on the following:

- Defining issues related to cultural diversity in medical practice;
- Identifying strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence the clinical care physicians furnish;
- Devising strategies to enhance skills toward the provision of care in a culturally diverse clinical practice; and
- Demonstrating the advantages of the adoption of the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health Care as appropriate in a clinical practice. The CLAS standards offer a framework and strategies to make practices more culturally and linguistically accessible.

Physicians can earn up to nine Category 1 Continuing Medical Education (CME) credits from the American Medical Association or nine CME credits from the American Academy of Family Physicians upon completion of the course. The course and CLAS standards are available at <http://thinkculturalhealth.org> on the Web.

To find additional information about how to become a Medicare provider or supplier, see the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

